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LONG-TERM CARE COMMISSION
JANUARY 22, 2007

LTC ADVISORY COMMISSION EXECUTIVE COMMITTEE MINUTES - DECEMBER 2006

LTC TASK FORCE RECOMMENDATIONS PROGRESS REPORTS - 9 DOCUMENTS

DEPARTMENT OF LABOR AND ECONOMIC GROWTH PRESENTATION - SUMMARY OF LTC PROGRAMS - 2 DOCUMENTS

NOTICE - MICHIGAN'S LTC CONNECTIONS JANUARY INFORMATIONAL FORUM

PUBLIC ACT 634 OF 2006 - SINGLE POINT OF ENTRY

PUBLIC ACT 674 OF 2006 - LTC PARTNERSHIPS

LONG-TERM CARE COMMISSION
EXECUTIVE COMMITTEE
DECEMBER 4, 2006
MINUTES

ATTENDEES: Marsha Moers, RoAnne Chaney, Jon Reardon, Hollis Turnham, Jane Church, Jackie Tichnell, Mike Head, Gloria Lanum

ABSENT: Christine Chesny

Discussion of LTC Commission Meeting - Head requested clarification regarding the Systems Transformation Grant Strategic Plan process and Commissioners who requested to participate in this process. It was indicated that the Commissioners were to contact Head regarding their participation. Tichnell will send a reminder to the Commissioners regarding this issue and a reminder to have the progress reports completed by January 14th.

Draft Minutes - Church is reviewing.

Budget Letters (Resolutions) - The two letters were finalized and sent to the Governor's office this week. There was some discussion regarding one letter referencing MIChoice only and the other referencing the entire long-term care budget line. This process may need to be repeated when the Governor's budget is proposed. The letters were also given to Pat Cannon (the Governor's Disability Policy Liaison) for distribution to other pertinent offices.

There was also discussion regarding the MIChoice wait list. At this point, there is little data available regarding persons on this list. The Department has some data available in the aggregate on a quarterly basis.

The last meeting did meet the Executive Committee expectations for the most part. The Resource document still needs refining. Tichnell will revise and send to the Executive Committee prior to the January meeting. The Department of Labor and Economics still needs to provide a summary of their long-term care connections. Tichnell will contact DLEG to be sure someone will be attending the January meeting. It was noted that the OSA handout was very useful.

Retreat - Turnham has had no response from the Lansing Convention Center. Head suggested using the Michigan Association of Community Mental Health Boards for arranging this retreat. (They have done so for the Office in the past.) It was agreed that Tichnell will contact the Board association for assistance.

The retreat should be scheduled for February 26/27, in Lansing, in lieu of the February Commission meeting. It should start around 10am on Monday and end around 2:30 on Tuesday, starting at 9:30 on Tuesday. There should be a social time Monday evening. Turnham, RoAnne, and Sheahan (independent facilitator) will develop a draft agenda for the retreat. This should also include priority setting using the progress reports. Sheahan will also talk to Brey regarding the retreat.

There was discussion regarding the Open Meetings Act. Tichnell and Head will pursue if this retreat meets the requirements of this Act.

The goals of the retreat are included in Turnham's retreat document distributed at the last Commission meeting.

January Commission Meeting Agenda - Turnham suggested the following on the agenda:

- DLEG presentation of LTC issues
- Progress reports
- Retreat

Tichnell should have the revised Resource document ready.

Executive Committee Conference Call after Commission Meetings - These meeting will occur at 3:30 pm the Monday following the Commission meeting. The Executive Committee should include the following dates on their calendars.

JANUARY 29, 2007	JULY 30, 2007
MARCH 5, 2007	SEPTEMBER 4, 2007
APRIL 2, 2007	OCTOBER 1, 2007
APRIL 30, 2007	OCTOBER 29, 2007
MAY 29, 2007	DECEMBER 3 2007
JULY 2, 2007	DECEMBER 26, 2007

Recommendation # 1: Require and Implement Person-Centered Planning Practices.

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
Recommended Actions The state should require and implement person-centered planning processes in statute and policy throughout the LTC system. As written in the Michigan Mental Health Code, "Person-centered planning" refers to "a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MCLA 330.1700(g). The process begins as soon as the person enters the LTC system and continues as the person seeks changes. Person-centered planning is designed to allow	Policy development and implementation is minimal across State agencies, conducted in various workgroups functioning in a fragmented fashion. 1. No new legislative proposals exist. 2. No new licensing and certification regulation developments are underway except for some work being done within the DHS/OCAL AFC-HFA Licensing Division. 3. SPE Pilot Contractors are including references to PCP in drafting of operational documents and procedures, with some PCP training being delivered among the sites. The SPE Pilot Evaluation Process is now in drafting and		

people to maximize choice and control in their lives. A consumer-chosen supports coordinator/facilitator located at each SPE (see below) will help the consumer navigate through a full range of services, supports, settings, and options. 1. Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system. 2. Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices.	development. The Department also has a "Policy and Practice Guideline Draft" for PCP in internal circulation (including SPE Pilot Contractors) and other workgroup activity ongoing within the OLTCSS. New Public Act 634 makes some reference to PCP as a requirement; no regulations or rules drafted yet. 4. No legislative proposal exists yet. 5. Training resources and activities appear to be available and locally underway. A capacity analysis for statewide training needs might help ascertain the success to date while projecting need. 6. Quality Assurance and Quality Management are performance criteria within the SPE Pilot Contracts. Related		

3. Require all Single Point of Entry agencies to establish and utilize person-centered planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects. 4. Include person-centered planning principles in model legislation to amend the Public Health Code. 5. Early in the implementation process, ensure the provision of training on person-centered planning to long-term care providers, regulators, advocates, and consumer. 6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system.	SPE Staff hiring has occurred. As these are in the context of SPE evaluation, a translation to whether and how SPE QA-QM constitutes compliance with PCP QI would help clarify much of the work still needed. Benchmarks: None of the Task Force benchmarks have been met.		

Benchmarks 1. Legislation requiring person-centered planning in the provision of LTC is passed in the current legislative session. 2. By January 1, 2006, the Department of Community Health, with the involvement of stakeholders, will establish in policy a person-centered planning protocol specific to LTC consumers. 3. Person-centered planning training is developed and provided to LTC providers, regulators, and advocates. 4. By October 1, 2006, each entity providing LTC services will have person-centered policies and training in place.			

5. Regulatory survey and program monitoring processes are revised to include a review of the integration of person-centered planning in supports coordination activities.			

DRAFT Progress Report on Task Force Recommendations

Recommendation #2: Improve Access by Adopting "Money Follows the Person" Principles.

Recommended Strategies by the Medicaid LTC Task Force	**Progress of State agencies and policies**	**LTCSS Commission Next Steps**	**Timeframes**
1. Establish consistent spend down provisions across all long-term care settings.			
2. Establish funding mechanisms to abide by the "money follows the person" principle.			
3. Amend and fund the MI Choice Waiver to serve all eligible clients.			
4. Establish reimbursement levels that realistically and appropriately reflect the acuity level and need for services and supports the client needs, consistent with federal limitations. (An immediate step would be to remove the current reimbursement cap on the MI Choice waiver.)			

Recommendation # 3: Create Single Point of Entry Agencies for Consumers.

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
1. Determine financial eligibility through the appropriate state agency. The process of determining eligibility also helps capture other public and private assistance programs for which the person is eligible. The SPE agencies will provide assistance to consumers in working through the eligibility application process. Single points of entry can facilitate speedier processing and identify barriers to processing. SPE agencies should work with other agencies to resolve barriers found in the system.	In progress at the Pilot Contractor implementation workgroup level consonant with some State level discussions. Medicaid authorization language in HB 5389 as well as obtaining financial determination of eligibility for publicly funded long-term care programs and reevaluation. Department staff report the following detail within the Pilot Contractor Workgroups: • Each site conducted a systems mapping dialogue to identify barriers to consumer service and access. • The interagency workgroup developed a work plan to streamline functional and financial access. This plan recognizes the need for policy changes at the state level as well as collaboration at the local level. • Options counselors will be trained and assist with application preparation.		

	Sites are working with medicaid and MMAP and others to develop training.		
2. Make supports coordination a key role of the SPE agencies. Consumers have the ability to change supports coordinators when they feel it is necessary to do so. Individuals should develop their support plans through the person-centered planning process. If the consumer chooses a supports coordinator from outside of the agency, the outside supports coordinator is held to the same restrictions on financial interest and should be held to same standards as SPE supports coordinator. The SPE retains the responsibility of authorizing services. a. The consumer can choose to have their supports coordinator broker their services or may broker their own services - whichever they prefer. b. The SPE agency will develop a protocol to inform consumers of their right to change supports coordinators. c. Establish methodologies to facilitate consumer control of what, by whom, and how supports are provided. Included will be methodologies for consumers to control their budgets or authorizations.	Imbedded in the RFP and next in development at the Pilot Contractor implementation level's Core Functions Workgroup. Preserved in HB 5389. Most supports coordinator hiring and/or assigning has been completed among the Pilots. Department staff input: Service authorization capacity is limited to LOC determinations for now. Pilot SPEs will assist in development of a general plan based on consumer preference and understanding of the choices; that Plan in turn will be used by providers as part of their process to allocate resources and implement service. Consumer directed care and brokering services are being initiated in 3 pilot projects that overlap with the SPE region. AAA Association Input: Questions raised about 1. relationship between supports coordination and options counseling. 2. position of		

	assessments, eligibilities determination, options counseling and person centered planning in the sequencing of core SPE functions. 3. boundaries setting between supports coordination responsibilities at the SPE and providers ends. 4. avoiding conflicts of interest in supports coordination. 5.the logistics of PCP training and monitoring across the multitude of supports coordinators at all levels.		
3. Make LTC transition a function of the SPE agencies. This service helps consumers make decisions about their own lives and facilitates a smooth transition between settings as their needs and preferences change.	Included in the RFP and Pilot Contractors implementation efforts in progress. Preserved in HB 5389 provision. Department staff input: • Transitions counseling is one essential element and target for the options counselors. Options counselors will be trained accordingly, use the experience gained in the nursing facility transitions initiative and approach and assist with transitions. • Pilots are working on developing Memoranda of Understanding with providers on referrals of		

	consumers who are seeking to understand their options. • SPE staff involvement with consumers will be ongoing and counseling will be available upon request, quarterly or when conditions change.		
4. Balance LTC through proactive choice counseling. The goal of proactive choice counseling is to catch people with LTC needs at key decision points (such as hospital discharge) and provide education and outreach to help them understand their options. Involve hospital administrators and social workers in developing protocols for the two systems to work together. This will involve outreach by the SPE to hospitals to explain their functions and benefits. Do outreach to the local physician community as well as other interested parties (Adult Protective Services, police, and others) working in settings where critical decisions are made about long-term care.	Included in the RFP and Pilot Contractors implementation in progress. Provided for in HB 5389. DCH staff input: Outreach meetings will continue to explore locating options counselors at hospitals. Focus of outreach activities during the first year will be on finding and building opportunities to reach people at key decision times.		
5. Mandate use of the SPE agency for individuals who seek to access Medicaid-funded programs. Individuals who are private pay will be able to access all of the services of the SPE agency. The Information and Referral/Assistance functions will be available to everyone at no cost.	Language in HB 5389 passed unanimously by the House September 19, 2006 mandates all Medicaid users within the given Regions go through the Pilot sites.		

Private pay individuals may have to pay a fee to access other SPE services (such services may be covered by long-term care or other insurance, however). LTC providers will be required to inform consumers of the availability of the SPE agency.	Department input: OLTCSS staff are checking to see if there is a way to mandate referrals before legislation or statewide implementation.		
6. Make a comprehensive assessment, or level of care tool, (developed by the proposed LTC Administration) available from the SPE agencies to determine functional eligibility for publicly funded LTC programs including Home Help, Home Health, Home and Community Based Services waiver (MI Choice), and nursing facilities. SPE agencies will use the Comprehensive Level of Care Tool for <u>all</u> persons coming to the SPE for assessment. The LTC Administration or MDCH is responsible for the development of the comprehensive tool. The SPE is responsible for ensuring the Preadmission Screening and Annual Resident Review (PAS/ARR) screen is done by the responsible agency when appropriate.	None. Only Medicaid LoC Determination tool in current use. Provided for in HB 5389. Department input: Interagency workgroup referred to above, has goal to explore "core" elements so a revised LOC tool could be used as intake for all/additional LTC programs.		
7. Require providers of LTC services to offer the Level of Care Determination Tool to private pay consumers. If a provider feels it cannot perform this assessment for the consumer, the provider should avail itself of the SPE agency's ability to perform this function.	None.		
8. Locate functional eligibility	Concept only in RFP, Pilot		

determination in the SPE agencies as long as there is aggressive state oversight and quality assurance including: 1) SPE agency required procedures to prevent provider bias and promote appropriate services; 2) SPE agency supervision, monitoring, and review of all assessments and support plans/care coordination; 3) state quality assurance monitoring; and 4) consumer advocate and ombudsman monitoring.	Contractors and Department, not slated for further development and implementation yet. Some provisions in HB 5389. Department input: Work has begun to allow SPE to perform LOC on a MOU basis. QA will flow from the evaluation framework being developed for the SPE pilots.		
9. The SPE agencies cannot be a direct provider of services to eliminate the tendency to recommend its own services to consumers and any other conflicts of interest. (An exceptions process must be developed to address service shortfalls, but in no event shall a SPE be a direct provider of Medicaid services.) The case management currently done by Waiver agents would be provided through SPE agencies under this system. The case management done by Department of Human Services (DHS) for Home Help would be provided through SPE agencies in this system. SPE agencies will encompass the entire array of Medicaid funded LTC supports.	HB 5389 preserves this principle + RFP and subsequently executed Pilot contracts set sequencing and some timetables for independent governance for each of the Pilots. Department input: 3 of 4 pilots will make application to create independent 501c3. All have requirements for an independent governing board.		
10. The funding for defined single points of entry is estimated to be between $60 and $72 million statewide. Of this total, approximately $31 to $36 million represents "shifted" dollars from current case management resources, while the	This roughly is the House fiscal analysis serving as background for HB 5389 and the current Executive Ordered Pilot sites. Resulting language in HB 5389 as passed by the House does not		

remaining amount reflects newly committed dollars needed for this purpose. The annual state share of newly committed dollars upon full implementation (at the end of year 3) will be $15 to $20 million. The Medicaid administrative matching formula should be used as the means of funding the SPE system. The SPE system will be phased-in over a three-year period. The estimate for first year costs for three SPE agencies is $12 to $16 million total funds. The State's GF contribution would be $6 to $8 million of which $3 to $4 million would be cost-shifted. SPEs will be routinely evaluated to ensure the needs of consumers are being met effectively and efficiently. A system wide efficiency gain of 1.7% in LTC expenditures as a result of establishment of single points of entry will fund the entire state system.	mandate statewide implementation. It only governs the Pilot programs or pilots to be. AAA Association Input: 1. observation that the shifting of case management funding to SPE services has not yet been executed. 2. observation that the time-frame for statewide expansion has expanded beyond three years.		
11. Develop a standard set of training and certifying criteria for SPE agencies set by the state. By establishing a standard set of certifying criteria, the state will be able to establish quality assurance measures that will provide consistency for consumers and stakeholders. Part of the standard criteria should be a demonstrated knowledge of local and regional resources to supplement Medicaid-funded supports.	Imbedded as criteria in the RFP and development in progress among current Department-Pilot Contractor efforts.		

12. Standardize the tools used by SPE agencies to allow for portability of benefits for the consumer if they move between regions as well as standardization of data collection for the state.	Specific MIS System Workgroup in progress at Pilot Contractor-Department level.		
13. Ensure access to bilingual and culturally competent staff at single points of entry who are trained according to the requirements of the SPE agencies.	Imbedded in the RFP and part of resource collaboration identification in each of the Pilot regions.		
14. Implement a quality assurance function focused on the SPE agency that emphasizes, but is not limited to, measures of consumer satisfaction.	Pilot Contractors in the midst of hiring/identifying QA managers + policy development within Contractor-Department Core Functions Workgroup soon in sequencing.		
15. The state needs to establish a comprehensive oversight system to ensure that all LTC consumers receive those supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible. Quality in this context will be measured by the consumer's satisfaction or lack thereof with the supports as provided.	Formation of Office of LTC Supports & Services + appointment of permanent Director under the Governor's Executive Order completed; some hiring still anticipated. Related legislation still pending in the House though reduced in scope ("Continuum Act" will merely aggregate current State LTC Laws).		
16. Expand advocacy processes for all LTC consumers. An advocate must be designated and legally granted the duty and authority to advocate on behalf of individual long-term care consumers, since much expertise is required for effective advocacy. The advocacy function	Principle preserved in HB 5389 @access to an independent consumer advocate and related information. No progress identifying this as of yet within the Pilots' implementation efforts.		

also needs to have a systemic approach to advocacy, similar to that performed by the State Long-Term Care Ombudsman or Michigan Protection and Advocacy Services. This more systemic approach would provide greater opportunity for the advocacy group to determine if there are any patterns of policy violations by SPE agencies or for patterns of misunderstandings of the policies by consumers or providers.			
17. Develop grievance and appeals processes that empower LTC consumers to challenge any denial of a requested support or any reduction, termination, or suspension of a currently provided support. The grievance process must be available not only for those issues, but also for issues not typically subject to the appeals process (such as the choice of provider).	Preserved in HB 5389 provision(s). Required by contract and will be written into policies and procedures. Not slated in Pilot implementation efforts as of yet.		

MICHIGAN MEDICAID LONG TERM CARE TASK FORCE
RECOMMENDATION #4: STRENGTHEN THE ARRAY OF SERVICES AND SUPPORTS
(EXPANDING THE ARRAY OF OPTIONS)

Establish an accessible, integrated service system that assures those in need of supports and services have a range of options that allow them to live where they choose. Within an assessed level of needs, consumers should have a menu of services and settings to choose from based on their individual preferences. Service delivery should be coordinated with existing providers and payers, including private payers, and provided in a wrap-around capacity. In the case of persons who desire to work, this includes services and supports for vocational and employment activities.

Recommendations for State Activities from the Task Force	Progress of state agencies and policies	Next Steps for OLTCSS Commission	Timeframe
Ensure the availability of the health and long term care services and supports (listed on Chart 1) as part of an integrated system of care		Seek clarity on the intent of Strategy/Action Step 1. Was it that all the services listed be available through MA funding or are other gov't programs included?	
Amend the MI Choice 1915(c) waiver to allow the provision of waiver services to individuals residing in licensed assisted living settings (adult foster care homes and homes for the aged).	Waiver renewal due June 2007. Internal DCH workgroup being formed to develop renewal document.	Clarify the state statute that currently prevents waiver individuals from receiving services in licensed settings. Research opposition to allowing provision of WA services in licensed settings. Is it financial? Other? Develop strategy to address the opposition and affect policy change.	
Ensure that comparable Medicaid programs allow supports and services to follow consumers into their preferred living arrangement.	OLTCSS exploring opportunities available to states under the DRA/MFP that will provide enhanced federal match for 12 months for services provided to individuals transitioned from nursing facilities to community settings.	Identify variables in functional and financial eligibility criteria between funding sources. Eliminate differences to achieve consistency among programs. Amend MA State Plan.	

Recommendations for State Activities from the Task Force	Progress of state agencies and policies	Next Steps for OLTCSS Commission	Timeframe
Revise Adult Foster Care (AFC) and Homes for the Aged (HFA) rules and regulations to allow for the provision of home health care in AFCs and HFAs on an ongoing basis.	Per DHS/Office of Children and Adult Licensing, there is no need to revise AFC or HFA rules to allow for the provision of home health care in AFC's and HFA's. Continuous nursing care, however, is currently allowed in AFC's and HFA's only within the realm of hospice care. Act 368 already requires the Department to not require a person to be moved from a HFA when provided with more than personal care, to allow the person to "age in place" if all concerned parties agree and the resident's care needs can be met. So it is only AFC's that currently are not allowed to have continuous nursing care if not a hospice patient and that would require more than a rule change, it would require a change in statute.	Determine whether issue is related to provision of continuous nursing care rather than the provision of home health care. Pursue modification of departmental policy and state statute to allow for ongoing provision of continuous nursing care in AFC and HFA settings in non-hospice situations.	
Create a HFA statute separate from the Public Health Code	No activity to report.	Determine continued relevance. Is this issue addressed in the LTC continuum bill?	

Recommendations for State Activities from the Task Force	Progress of state agencies and policies	Next Steps for OLTCSS Commission	Timeframe
Create an Assisted Living Regulatory and Education Workgroup to: 1) study and propose modifications to existing AFC and HFA statutes and rules to ensure they meet stated philosophies and principles of quality and accountability, person centered planning, money follows the person, and availability of Medicaid reimbursement for services provided in assisted living. 2) Study the array of unlicensed assisted living arrangements. Determine whether existing licensing statutes are appropriately enforced. 3) Develop consumer education materials to raise awareness about the full array of assisted living services using clear distinctions regarding the applicable state regulations. 4) Determine the feasibility and appropriateness of developing a legal definition of "assisted living" to allay public confusion as to the meaning of the term and its current use in describing a wide variety of licensed and unlicensed settings.	No activity to report.	Identify a Commissioner to take a lead role in convening stakeholders to make recommendations to the Commission on these four items. At a minimum, stakeholder is defined as MCAL, MALA, MAHSA, DCH, DHS, SLTCO, consumer.	

Recommendation # 5: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.

Recommended **Strategies by the Medicaid LTC Task Force**	**Progress of state agencies and policies**	**LTCSS Commission Next Steps**	**Timeframes**
1. Convene a broad-based coalition of aging, disability, and other organizations.	**OSA:** Healthy Aging Task Force. **What is the charge? What is the representation of aging consumers and how are the aging healthy aging issues of people with disabilities under 65 addressed/incorporated?**		
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).	**OSA Strategic Plan: Goal V-F. LIVABLE COMMUNITIES STRATEGY**: Ensure the availability of information, training, technical assistance and advocacy regarding livable communities. **Indicators:** Goal V-F, Indicator 1: By 9/30/07, a "Communities for a Lifetime" Tool Kit will be available electronically and in hard copy. Goal V-F, Indicator 2: By 9/30/07, demographic data on older adults will be available and distributed as requested by businesses, community organizations and state/local governments. Goal V-F, Indicator 3: By 9/30/07, recruit at least three (3) communities to complete an "Elder Friendly" assessment. Goal V-F, Indicator 4: By 9/30/07, a baseline of senior centers that begin a certification process will be established. Goal V-F, Indicator 5: By 9/30/07, the number of senior centers identified as a focal point in AAA Multi-Year and Annual Implementation plans for community activities for older adults, including "young" seniors will increase from	**Do/should SPEs be charged to do this as part of resource database?**	

	the number in FY 2006. **Are prevention, chronic care and caregiver supports all included in the assessment? How many municipalities have/will participate?** ★ **How can the Surgeon Generals WOW (Wellness) resources listed by county include aging/ disability, chronic care and caregiver resources?**		
3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.	**OSA Strategic Plan: II-B. CULTURAL COMPETENCY AND TARGETED OUTREACH STRATEGY:** Ensure that minority, disabled and socially isolated older adults have access to culturally appropriate services. **Indicators:** Goal II-B, Indicator 1: By 9/30/07, older minority, Hispanic and rural older adults will receive aging network services at a rate that is 1.5 times the percentage of total older minority, Hispanic and rural populations as reported in the 2000 U.S. Census. Goal II-B, Indicator 2: By 9/30/07, OSA brochures and materials for public distribution will be available in large print or by tape for the visually impaired and electronically in languages for members of minority and ethnic groups that comprise 10% of the Michigan population or more. Goal II-B, Indicator 3: By 9/30/07, sustainability plans will be developed for each of the AAAs administering Older Refugee Outreach Programs. Goal II-B, Indicator 4: By 9/30/07, OSA staff will be surveyed to establish a cultural competency development plan to build capacity within OSA. **How can strategies be developed and implemented at the local level for prevention, chronic care, and caregiver support programs and include these cultural competency strategies?**		
4. Develop and support programs to address	**Public Health:** **Division of Chronic Disease and Injury Control**		

prevention, chronic care, and caregiver supports.	**Division of Health, Wellness and Disease Control** Public health prevention and chronic care programs include: ➢ Cardiovascular ➢ Cancer ➢ Hepatitus ➢ Osteoporosis ➢ Diabetes ➢ Injury Prevention ➢ Arthritis ➢ Dementia ★ Michigan Steps Up Program promoting exercise and health includes people with disabilities and people who are aging. **OSA Strategic Plan: V-A. FALLS AND SERIOUS INJURY STRATEGY:** Increase awareness of information about the frequency of falls among older adults. **Indicators:** Goal V-A Indicator 1: By 9/30/06, have collections of promising practice fall prevention literature and web-based information available to the aging network and general public. Goal V-A, Indicator 2: By 9/30/06, include up-to-date fall prevention information within at least two statewide or regional trainings provided by the aging network, AAAs, Michigan State Housing Development Authority (MSHDA), or other housing organizations.		
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.	**OSA:** Healthy Aging Initiatives tying to incorporate informal caregivers. **There seems to be little to no initiatives targeted directly to informal caregivers. What has to happen to change this?**		

6. Develop wrap-around protocols for caregiver/consumer support needs.	**OSA Strategic Plan: II-F. DEMENTIA SERVICES STRATEGY:** Increase the capacity of the aging network to serve older adults with dementia, as well as their caregivers. **Indicators:** Goal I-F, Indicator 1: By 9/30/07, aging network providers will participate in the local dementia wraparound projects. Goal I-F, Indicator 2: By 9/30/07, AAA staff will know and participate in the Academic Detailing Project for physicians. Goal I-F, Indicator 3: By 9/30/07, AAA staff will be included as members of the Michigan Dementia Coalition. Goal I-F, Indicator 4: By 9/30/07, OSA will provide program information and resources to dementia activities, including the Dementia Coalition, DCH dementia block grant review and the AoA dementia grant. Goal 1-F, Indicator 5: By 9/30/07, OSA National Family Caregiver Support Program data will reflect additional family members of people with dementia using respite or day care services. **Are there plans for sustaining this initiative or spreading wrap-around protocols beyond dementia?**		
7. Develop a public health caregiver support model.	**How can this get initiated?**		
8. Create initiatives and incentives to support caregivers.	**OSA Strategic Plan: II-C. CAREGIVER STRATEGY:** Provide resources to support services that extend the time caregivers, including those involved in kinship care, are able to care for their loved ones. **Indicators:** Goal II-C, Indicator 1: The number of caregivers provided respite from their caregiving responsibilities as compared to the number of estimated caregivers in Michigan. Goal II-C, Indicator 9: By 9/30/07, each PSA will have all five categories of caregiver services available as		

	authorized by the Older Americans Act. **What are the five categories?**		
9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).	**OSA Strategic Plan: I-B. HEALTH PROMOTION** **STRATEGY:** Promote evidence-based health and wellness activities that reduce the incidence of chronic disease, early death and disability. **Indicators:** Goal 1-B, Indicator 1: By 9/30/07, the statewide Senior Physical Activity and Wellness Committee will meet on a quarterly basis and oversees Senior Health and Fitness Day and the Active Options Database. Goal 1-B, Indicator 2: By 9/30/07, the number of AAAs offering health and wellness programs will increase by two (2). Goal 1-B, Indicator 3: By 9/30/07, A PATH infrastructure is developed through appointed regional coordinators with classes offered on a regular basis. Goal 1-B, Indicator 4: By 9/30/07, Each PSA sends at least one (1) person to training for evidence-based programs. Each PSA offers at least 1 evidence-based program per year. Goal 1-B, Indicator 5: By 9/30/07, there will be an increase in the number of "hits" on the health promotion web pages on MISeniors.net. Goal 1-B, Indicator 6: By 9/30/07, three PSAs will offer at least one (1) Stanford Chronic Disease Self-Management Program. Goal 1-B, Indicator 7: By 9/30/07, each PSA will offer at least four (4) evidence-based programs per year, in addition to the Stanford Chronic Disease Self-Management Program. **Public Health:** The Primary Care Consortium Strategic Plan Implementation Goal: all clinicians, patients, payers, purchasers, and policy-makers will collectively accept and support health promotion as the foundation for delivery of		

	primary care health services in Michigan. (includes Ed Wagner model for chronic care.) **How can these initiatives report and spread results?**		
10. Create incentives for implementing culturally competent chronic care models and protocols.	**OSA;** 16 AAAs have licenses to teach Wagner model Wagner model of chronic care and self-management. **How can these initiatives report and spread results?** **How can cultural competence be assured in these initiatives?**		
11. Develop and implement chronic care protocols, including, but not limited to: a. medication usage. b. identifying abuse and neglect, caregiver burnout/frustration. c. caregiver safety and health.	**Public Health:** The Primary Care Consortium Strategic Plan Implementation Goal: all clinicians, patients, payers, purchasers, and policy-makers will collectively accept and support health promotion as the foundation for delivery of primary care health services in Michigan. **How can these initiatives report and spread results?** **How can these three specifics be included and reported?**		
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.	New Older Americans Act references. **Are there any initiatives in development?**		
13. Investigate grant opportunities to pilot chronic care management models.	Several grants. **Can a list be developed?**		

Recommendation # 6: **Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.**

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
A. <u>Long-Term Care Commission</u>. **<u>Strategies / Action Steps</u>** All stakeholders will have meaningful roles in the ongoing planning, design, implementation, and oversight efforts to achieve the recommendations of the Michigan Medicaid Long-Term Care Task Force and the long-term care efforts of the state. Consumers, families, and their representatives will be the principal participants. <u>Appointment</u> The Michigan Long-Term Care Commission will be established in state legislation with the governor appointing members with concurrence of the state senate for three-year staggered terms.	State Legislation introduced in the House by Barbara Vander Veen in HB 5762, referred to Committee on Senior Health, Security & Retirement on 4/18/06. Problems with this bill: • more narrowly defines who can be appointed as a consumer, excluding consumer advocates' eligibility; • calls for 25 voting members and 5 ex-officio members. The Executive Order calls for 17 voting members, 5 ex-officio members and a special advisor • Work group E recommendations do not mention the Senate, nor does the Executive Order, but the Task Force report says appointments are "with concurrence of the state senate". Clarification is needed.		

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
<u>Membership</u> 1) The commission shall consist of twenty-five members appointed by the governor. Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers, at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in LTC research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.	The Commission currently consists of only 16 members. There are: 8 members representing consumers (Linda Mulligan was a consumer rep) 3 representing providers 3 representing direct care workers 2 representing the general public. The general public reps are Linda Ewing and Reverend Charles Williams. • Both Workgroup E and the Executive Order call for a member from a university with expertise in long-term care.		
2) One representative each from the SPE network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services, and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff shall be provided and shall serve as resources to the commission and shall assist the commission as needed.	Ex-officio membership includes SLTCO Sarah Slocum, MDCH Director Janet Olszewski, OSA Director Sharon Gire, and the acting director of DLEG and also Marion Udow from MDHS. One of these is a "special advisor". A representative of MPAS is indicated by the report and is not included. Also, we have no SPE representatives yet.		
3) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 1.	One resignation (Linda Mulligan from the U.P.) so far-need to appoint a replacement from the consumer category. OLTCSS reports that contact has been made with the Governor's appointments office regarding finding a replacement for Linda.		
4) Commissioners are entitled to receive a stipend, if not otherwise compensated, and reimbursement for actual and necessary expenses while acting as an official representative of the commission as defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support	Reimbursement has been provided to offset travel expenses for some Commissioners. See Jackie Tichnell for information on compensation if needed.		

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
workers or personal assistants, support facilitation or other persons serving them as secondary consumers.			
5) The governor shall designate one person from among the consumer membership to serve as a chairperson of the commission, who shall serve at the pleasure of the governor.	Marsha Moers is current chair; the Commission has voted to establish a vice-chair and elected Hollis Turnham.		
<u>Authority</u>			
1.) Policy and Programs In partnership with the executive branch and the appropriate department or designated long-term care entity, the Commission will develop and recommend policy regarding all LTC programs including the public awareness and education campaign.	Executive Branch Representatives Olszewski & Gire & Udow, OLTCSS formed with Mike Head as director		
2.) Budget In partnership with the executive branch and the appropriate department or designated long-term care entity, the Commission will participate in the development of the budget for Michigan's LTC system that implements established policy and meets demonstrated consumer preferences and needs. The commission will make recommendations regarding the same to the legislature.	We have not done this yet. How we are to be involved is unknown at this time, and OLTCSS reports that budget development for FY 2008 is not yet underway.		
3.) Spending The Commission will continuously monitor spending and budget implementation including how well expenditures match policy decisions and initiatives based on demonstrated consumer preferences and needs.	We have discussed in the past the necessity for increased funding for the MI Choice program if consumers are to have meaningful choice and in order to honor consumer preferences.		
4.) Performance and Quality of Single Point of Entry Agencies The Commission will help develop and approve quality assurance measures for monitoring the efficiency, effectiveness, and performance of local initiatives including local oversight of and consumer involvement with the SPE agencies. Once the LTC commission is established, it will work with DCH or the LTC administration in the selection and oversight of the agencies.	The full Commission was not included in selection of the agencies for the demonstration grant; they were chosen by a committee. Members represented consumers, providers, state departments, advocates and stakeholders, and were determined by the Interim Director (Jan Christensen) in consultation with staff. RoAnne Chaney was a member, as were several of the ex- officio Commission members.		

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
Using the evaluations and feedback from the performance and quality assurance monitoring done by the department, the Commission will make recommendations to improve the operational performance of SPE agencies and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public. The Commission will play a similar role for all other entities in LTC including new initiatives involved in rebalancing the system. **B. Public Awareness and Education Campaign** **Strategies / Action Steps** 1. Develop criteria for and authorize hiring of a social marketing firm to develop a marketing and public awareness campaign that includes the following components: • Uniform identity including name and logo for the single point of entry agencies; • Public awareness campaign that includes radio and television public service announcements, print ads, brochures, and other appropriate educational materials; and • Local media and awareness tool kit that single point of entry agencies can use to outreach to and raise awareness among all stakeholders. 2. Develop criteria for and authorize hiring of a web design firm and an expert in creating materials for the targeted populations (e.g., seniors and people with a variety of disabilities) to design informative, user friendly web site that can serve as a single point of information regarding LTC in Michigan. This web site will maintain the look, name, and logos developed for the marketing and public awareness campaign. The web site will include comprehensive information on LTC, have well-developed keywords and navigation capabilities, and be linked	The Office feels some of the work will be better performed by committees and that at the very least, monthly updates will certainly keep Commissioners abreast of activities and progress. • The language of Workgroup E clearly indicates the entire Commission should be involved. There is a uniform identity, **Long-Term Care Connections**, and work on a logo is underway. D-AAA has started doing some presentations and newspaper articles on their own about the SPE, but none of the others have. Some targeted marketing will be done in conjunction with the pending "Own your Future" campaign, which will be the introductory publicity outreach. This is pending. The state website is being updated and the D-AAA local website is also being developed; the other sites have not started this yet. The intent is to have a single, statewide web-based resource database. • The Commission has not developed criteria or authorized hiring for either of these steps.		

***Recommendations* for State Activities from the Task Force**	**Progress of state agencies and policies**	**Next Steps for OLTCSS Commission**	**Timeframe**
to major search engines and other relevant web sites in a way that makes them easily accessible.			
3. Establish criteria for and authorize the development of curricula for education of professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) that can be included in academic programs and continuing education requirements for licensing and/or certification and will be implemented over time.	No progress to report.		
4. Establish criteria for and authorize development of a variety of training and educational materials targeted to the specific groups described above (state employees involved in long term care, legislators and their aides, and children K-12).	No progress to report.		

DRAFT Progress Report on LTC Task Force Recommendations

Prepared 11-14 - 06

Recommendation #7: Establish a New Quality Management System. Page 20 of the Modernizing Michigan Medicaid Long-Tem Care.

Recommendations for State Activities from the LTC Task Force	Progress of state agencies and policies	Next Steps for LTCSS Commission	Commission Timeframe
1. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements.	MI Choice Quality Collaborative has developed some consumer experience/satisfaction measurements.		
2. Include a strong consumer advocacy component in the new system.	Proposal drafted by State LTC Ombudsman. No progress on implementation.		
3. Review and analyze current performance measures (both regulatory and non-regulatory).	No progress.		
4. Design performance measures that move Michigan's LTC system toward this vision of quality.	No progress.		

5. Invest quality management functions in a new Long-Term Care administration. The administration would improve quality by consolidating fragmented pieces of LTC, and defining and establishing broader accountability across the LTC array of services and supports. [Section 7 of the model Michigan Long-Term Care Consumer Choice and Quality Improvement Act in the appendix discusses some of the quality management functions in detail.]			
Benchmarks to measure State Activities from the Task Force	Progress of State Agencies and Policies	Next Steps for OLTCSS Commission	Timeframe
1. Consumer determination of quality is the priority quality measure.			
2. Person-centered planning is implemented throughout the LTC system.	Training developed and presented in parts of state. PCP included in SPE pilot contracts and work plans.		

3. Oversight of QM is established within LTC Commission and LTC administration.			

Progress Report on LTC Task Force Recommendations

For distribution 1.14.07

<u>Recommendation # 8 Workforce Development:</u> Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices. Pages 21-22 of the Final Report of the Michigan Medicaid Long-Term Care Task Force.

Recommendations for State Activities from the LTC Task Force	Progress of state agencies and policies	Next Steps for LTCSS Commission	Commission Timeframe
1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers.	The Bureau of Workforce Programs (BWP) within DLEG provides technical assistance and educational sessions for the state's Regional Skills Alliances (RSAs); many of the RSAs are focused on health care and long-term care specifically. Recently educational sessions have focused on retention and career advancement for entry-level health care workers. Several MWAs through either their Regional Skills Alliances (RSAs) or federal grants are exploring new uses of WorkKeys or new assessment tools, JobFit. **Screening process not associated with MWAs:** Beginning with federal funding, all new employees as of April 1, 2006, working in licensed nursing homes, hospital long-term care units, adult foster care homes, homes for the aged, certified home health agencies, hospital swing beds, ICF-MR facilities, and psychiatric hospitals have been screened for criminal convictions in Michigan and through the FBI's		

	state and national fingerprint records. State Public Acts 25-29 of 2006 also have other provisions. Over 130,000 people who have "direct access" to consumers or their records have been screened.		
***Recommendations* for State Activities from the LTC Task Force**	**Progress of state agencies and policies**	**Next Steps for LTCSS Commission**	**Commission Timeframe**
2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings.	State (DHS and DLEG) is piloting new JET (Jobs, Education, & Training) program to replace Work First in four locations in 2006. JET will be expanded to 29 sites in 19 different counties, involving 13 different Michigan Works! Agencies by December 2006. JET emphasizes more rigorous individual assessment, shared electronic screening tools, and access to jobs and training that fit identified skills, aptitude and interest. This process will better identify candidates for LTC careers. For more info: http://www.michigan.gov/cis/0,1607,7-154-41500---,00.html		
3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers.	Tools are being developed that could be helpful but no recruitment campaign to bring people into long-term care careers has, as yet, been created or executed. DCH has developed and launched a website covering all careers in Health. It is www.michigan.gov/healthcareers---all health careers The MI Health Council [www.mhc.org] and the		

	MI Center for Nursing are working on initiatives to attract men to nursing. DCH's Chief Nurse Executive is working with the nursing programs in the state's community colleges, colleges, and universities to attract students from a diverse range of backgrounds.		
***Recommendations* for State Activities from the LTC Task Force**	**Progress of state agencies and policies**	**Next Steps for LTCSS Commission**	**Commission Timeframe**
4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care.	Tools have been developed but they have not been coordinated by state agencies to promote careers opportunities in long-term care. Through the Adult Abuse and Neglect Prevention Training evaluation process, basic demographic data on more than 11,000 direct care staff is be collected for the first time in the state. The staff are working in a wide array of long-term care settings. Some RSAs have created information on health care careers generally. DCH, DLEG, and DHS have created a general health care workforce center. www.michigan.gov/healthcareers. The top five health careers in Michigan (largest number needed) are: 1. Registered nurses 2. Nursing assistants 3. Home health aides 4. Personal care attendants 5. Licensed practical nurses		

	The same departments along with the Department of Education have created an online health care workforce center. www.michigan.gov/healthcareworkforce center. See discussion of career lattice model directly below.		
***Recommendations* for State Activities from the LTC Task Force**	**Progress of state agencies and policies**	**Next Steps for LTCSS Commission**	**Commission Timeframe**
5. Improve and increase training opportunities for direct care workers (DCW) to allow for enhanced skill development and employability.	With federal grant, training in adult abuse and neglect prevention is being offered to 11,000 workers who have "direct access" to LTC consumers or their financial information. To be completed in 9/2007. With a federal grant administered by DCH's Bureau of Mental Health and Substance Abuse, some home help providers are receiving training in dementia care. Traverse City based RSA is offering another round of dementia, body mechanics, and other 4 hours courses to DCWs in their 13 county service area. The Medical Services Administration of DCH has applied for a technical assistance grant from CMS to expand training opportunities for Home Help providers. DLEG helped fund the development of a career		

	lattice program model to increase the number of CNAs, LPNs and RNs working with CAEL (Council for Adult and Experiential Learning). DLEG's Regional Skills Alliances (RSA) Learning Institutes will cover strategies to address training, funding, and state standards. With funding from MSU and the Office on Services to the Aging, a Home Management Skills curriculum focusing on home cleaning, nutrition, food shopping and cooking has been created for home care workers. In collaboration with stakeholder, DCH has created a curriculum to train "dining assistants" in nursing homes. The training and use of dining assistants has been piloted in nine Michigan homes. The MI Dementia Coalition has created a Guide for Direct Care Workers to the knowledge and skills needed to deliver quality dementia care. While not a curriculum, the guide is intended to assist workers in a self-assessment of their skills in providing supports and services to those with dementia.		
***Recommendations* for State Activities from the LTC Task Force**	**Progress of state agencies and policies**	**Next Steps for LTCSS Commission**	**Commission Timeframe**
6. Increase training opportunities	DCH has funded a round of training to build the		

for employers to improve supervision and create a positive work environment.	capacities of CMHs to aide consumers who want to use consumer directed supports and be the employer and direct "supervisor" of staff.		
***Recommendations* for State Activities from the LTC Task Force**	**Progress of state agencies and policies**	**Next Steps for LTCSS Commission**	**Commission Timeframe**
7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record.	MiOSHA (Occupational Safety and Health Administration) did outreach to LTC stakeholders and the RSAs to explain the MiOSHA offered grants for safety training. While some LTC organizations applied for MiOSHA grants to conduct safety trainings, none were awarded funding. Some of the funded trainings are relevant to and are being offered to long-term care organizations.		
8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer.	Legislature and Governor approved: A. Home Help providers' wage rates increased on 10/1/06 to a floor of $7.00 per hour and existing county wage rates that exceeded $7 were increased by $0.50 per hour. B. A 2% increase to CMH boards for wage increase of DCWs in FY 2007. The increase has not yet been implemented by DCH. C. State earned income tax credit (EITC) for 2008 tax year. D. $10 a day in personal care supplement to adult foster care homes and homes for the aged in FY 2007 to cover increases in the state minimum wage.		

9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families.	Work of federally funded State Planning Grant for the Uninsured completed. The final report recommends health care coverage for all Michigan residents. www.michigan.gov/spg DCH is negotiating with federal government for a waiver to cover 550,000 uninsured residents whose income is below 200% of poverty. Michigan First Health Plan intends to offer a health insurance product to people living at this income level. Negotiations continued with the CMS over the federal share of funds that will be committed to the effort.		
***Recommendations* for State Activities from the LTC Task Force**	**Progress of state agencies and policies**	**Next Steps for LTCSS Commission**	**Commission Timeframe**
9.1 State agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports.	No progress identified. Relevant primary departments: DCH, DHS		
10. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and	DCH has accepted the work of one RSA (Michigan Direct Care Workforce Initiative) that "revises" the state's Michigan Model Certified Nursing Assistant (CNA) curriculum. The revisions remove obsolete references (mercury thermometer, etc) from the training that must be taken to work in the state's Medicaid certified nursing homes. DCH plans to implement the revised curriculum in Jan. 2007.		

those in need of rehabilitative and restorative services across LTC and acute care settings.	The same RSA group is exploring enhancing the CNA curriculum beyond the federal 75 hour minimum and the federal minimums for approving "trainers" and "programs." Other developed curriculums include the Adult Abuse and Neglect Prevention Training, the dining assistants in nursing homes and the Home Managements skills training for home care workers.		
11. LTC administration will track employment trends, including turnover rates.	NOTE: The recommendation speaks to a LTC Administration which had broader responsibilities than the Office of LTCSS created within DCH. DCH, DLEG, DHS, and Dept of Education have developed a healthcare workforce center. The website notes the number of RNs, LPNs, aides and personal care attendants that will be needed in all of health care but no specific focus is placed on LTC. www.michigan/gov/healthcareworkforcecenter There is discussion within the SPE pilots of tracking consumer needs that are not met due to "worker shortages." As noted above, some very basic demographic data is being collected from the 11,000 direct access staff who are taking the Adult Abuse and Neglect Prevention Training. Relevant departments: DLEG, DCH, DHS		

Benchmarks to measure State Activities from the Task Force	Progress of State Agencies and Policies	Next Steps for LTCSS Commission	Timeframe
A. Measurable increase in LTC employer use of MWA services and in LTC employer hiring of Work First participants.	No progress identified. Not clear that system has capacity to track or measure change. Relevant department: DLEG See #1 and #2 above.		
B. More qualified Work First participants are recruited and successfully employed in the LTC industry, while continuing their education for entry into licensed occupations.	No progress identified. Not clear that system has capacity to track or measure change. Relevant department: DHS and DLEG See #2 above.		
C. Higher compensation packages and increased training opportunities.	Compensation: Higher salaries, moving from a floor of $5.15 an hour to $7.00 and higher, for 45,000+ Home Help providers. Increased state funding earmarked for compensation for DCWs associated with CMHs. Increase in state minimum wage rates. Training:		

	11,000 direct access staff to be trained in abuse and neglect prevention. Several 100 DCWs in Traverse City area trained with MWA funding. 59 people trained as dining assistants.		
Benchmarks to measure State Activities from the Task Force	Progress of State Agencies and Policies	Next Steps for LTCSS Commission	Timeframe
D. Continuously and incrementally reduced turnover rates over the next decade.	No progress identified. System does not have the capacity to identify turnover rates or to track change across time within any setting or services. For some settings and services, state does know know the number of people employed or served. Relevant departments: DCH, DHS, DLEG		
E. All people working in LTC have access to affordable health care coverage.	No new coverage opportunities created. Relevant departments: DCH, DHS See #9 above.		
F. Increased use of creative management and workplace practices.	DCH sponsored Facility Innovations Design Supplemental (FIDS) program has recruited as many as 75 Medicaid funded nursing homes to remodel or replace their facilities and to implement "culture change" activities over three years. Within DHS, the Office of Children and Adult		

	Licensing is changing its survey process for adult foster care homes and homes for the aged based on the system used in WI. Relevant departments: DCH, DHS, DLEG		
Benchmarks to measure State Activities from the Task Force	Progress of State Agencies and Policies	Next Steps for LTCSS Commission	Timeframe
G. Use of data and consumer satisfaction to inform a system of services, state policies, and employer practices that result in consumer-driven outcomes.	Some tools are being developed but no systemic approach has been developed or implemented. There is discussion within the SPE pilots of tracking consumer needs that are not met due to "worker shortages." Relevant departments: DCH, DHS, DLEG		
H. Increased opportunities and incentives for LTC employers and their supervisory personnel to improve supervisory and leadership skills to create positive workplace environments and relationships to reduce turnover.	See # 6 above. Training for consumers who are directly hiring and supervising Also, see F above and the "culture change" possibilities in FIDS nursing homes.		

LTC FINANCE COMMITTEE JANUARY 2007

Recommendation #9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud

Recommendations for State Activities from Task Force	Progress of State Agencies and Policies	Next Steps for OLTCSS Commission	Timeframe
Benchmark 1: Increased state and federal support will be available to implement Person-Centered Plans and consumer choice options. *Case Mix System-Not assigned a specific action number, but a key focus of the report.* Recommended Action: Action 9: Michigan should encourage and strengthen local and regional programs that support caregivers in their care giving efforts. Action 17: Medicaid eligibility policies should be amended to: a) Permit use of patient pay amounts for past medical bills, including past nursing facility bills. b) Require full certification of all Medicaid nursing facilities. c) Require dual certification of all nursing facilities. Action 18: The task force recommends full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be $4.3 million. Of the increase, $2 million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; $2.3 million would go to the external advocacy organization outlined in Section 8 of the Model Act.		Facilitate the formation of a stakeholders group that examines this method of payment and fully explore it and alternatives. Clarify the intent Clarify the intent Clarify with State Ombudsmen's office	

Recommendations for State Activities from Task Force	Progress of State Agencies and Policies	Next Steps for OLTCSS Commission	Timeframe
Benchmark 2:A reduction of inappropriate asset and income sheltering will be achieved. Recommended Action: Action 4: Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program. Action 10: An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation. Action 11: There should be ongoing review and strengthening, along with strict and consistent enforcement of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility. Action 12: There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable individuals. Action 13: State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care. Action 14: New legislation for the regulation by the state of "trust mills" and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulation, registration of out-of-state companies, and prescreening of sales materials.	***Bills introduced in last legislative session without passing. Governor Granholm included estate recovery in her "Own Your Future" campaign on Dec. 1.***	Gather information regarding which areas of government are responsible and how the current processes function Determine responsibility	

Recommendations for State Activities from Task Force	Progress of State Agencies and Policies	Next Steps for OLTCSS Commission	Timeframe
Benchmark 3: Improved federal-state funding partnership will be achieved. Recommended Action: Action 2: Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports. Action 3: The Michigan Congressional Delegation should: a) Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance. b) Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid. c) Urge Congress to revise the current Federal Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application. Action 15: Appropriate state agencies should analyze and quantify the relationship between public and private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars. Action 16: The state should study and pursue aggressive Medicare recovery efforts.		Identify staff departments for compiling data. 1. Identify and consults with national association with knowledge regarding federal initiatives. 2. Advocate with key Michigan members of Congress. Determine current state of activity and department responsible Associated with dual eligibles?	

Recommendations for State Activities from Task Force	Progress of State Agencies and Policies	Next Steps for OLTCSS Commission	Timeframe
Benchmark 4: An increase in the number of Michigan citizens with LTC insurance will be achieved. Recommended Action: Action 5: Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers. Action 6: Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of the Long-Term Care Insurance Partnership Programs b) expand the state employees' self-funded, long-term care insurance program c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance. Action 7: Tax credits and tax deductions for the purchase of long-term care insurance policies and for "out of pocket costs" for LTC should be considered.		Gather information	

Recommendations for State Activities from Task Force	Progress of State Agencies and Policies	Next Steps for OLTCSS Commission	Timeframe
Benchmark 5: An adequate allocation of finances and resources across the array of supports and services will reflect informed consumer choices in the delivery of LTC services and supports. Recommended Action: Action 1: Michigan should decouple its estate tax from the federal estate tax to make more revenue available. Action 8: A "special tax exemption" for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a $1,800 exemption proposed in legislation introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less that $1 million. As an initial step, Michigan should adopt a Case-Mix reimbursement system to fund LTC services and supports. This approach sets provider rates according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted.		Commission advocacy for legislation	

Department of Labor and Economic Development

Report to Long Term-Care Commission

January 2007

DLEG provides services to disabled persons as well as meeting the workforce needs of employers serving the population.

Services to Disable Persons:

- Michigan Rehabilitation Services assist disabled customers to determine an employment goal, develop an employment plan, follow and achieve the goal of the plan. The following services are provided free of charge: disability assessments, vocational evaluations, counseling, job placements services and follow up services. MRS also provides Independent Living/Independent Living Center grants to help maintain a statewide network of independent living centers, develop new centers and reimburse individuals for the personal assistance they need to enter and maintain employment. http://www.michigan.gov/mdcd/0,1607,7-122-25392---,00.html
- Michigan Commission for the Blind assist people who are blind or visually impaired to achieve employment and independence. MCB provides counseling and training in skills for daily living, vocational training, evaluations and vocational counseling. http://www.michigan.gov/cis/0,1607,7-154-28077_28313---,00.html
- Bureau of Workforce Programs provides funding to Michigan Works One Stop Centers throughout Michigan to assist job seekers, including disabled customers. Services include outreach, intake, initial job assessment, and job placement, on the job training and other career skills training. http://www.michigan.gov/mdcd/0,1607,7-122-1678---,00.html

Services to Employers:

- Bureau of Workforce Programs assist employers in meeting workforce needs through the services of the Michigan Works One Stops, as well as regional planning efforts such as the 21st Century Regional Planning Initiative that promotes a regional approach to address the long term workforce needs of employers and workers. In addition the bureau supports Regional Skills Alliances that are sector-based partnerships among employers, educational institutions, training providers, economic development organizations, and public workforce agencies. There are currently 12 health care sector RSAs.
- Michigan Rehabilitation Services works with employers to assess accommodation needs, to place job applicants, and to assimilate disabled workers in to their workforce.

- Michigan Commission for the Blind works directly with businesses and provides services to employers at no cost to help them retain or hire blind or visually impaired employees.

DEPARTMENT OF LABOR & ECONOMIC GROWTH
BUREAU OF WORKFORCE PROGRAMS

January 2007
Workforce Programs

Bureau Operated Programs

- **21st Century Regional Planning Initiative**
  The 21st Century Regional Planning initiative is an attempt to promote a regional approach to address immediate and long-term workforce needs of employers and workers. State grants were awarded to thirteen regions made up of one or more Michigan Works! Agencies. The grant supports the collaborative efforts between the Michigan Works! Agencies and regional partners including local government leaders, labor representatives, business/chamber of commerce leadership, community colleges, ISDs and other education providers, local economic development agencies, and community service agencies.

- **Michigan Regional Skills Alliances (MiRSAs)**
  A MiRSA is a regionally and industry-based consortium or partnership among employers, educational institutions, training providers, economic development organizations, and public workforce system agencies. Funded with Workforce Investment Act state dollars, each partnership addresses workforce issues within a particular industry such as healthcare, construction and advanced manufacturing. Currently, Michigan has thirty-one MiRSAs within eight industry sectors.

- **Rapid Response Team Process**
  The Rapid Response Team addresses the needs of employers and employees when a facility closure or layoff impacts at least 50 workers. Meetings are scheduled to provide employers and employee representatives an opportunity to obtain invaluable information about dislocated worker services that are available locally and free to eligible applicants. The Rapid Response Team works together to ensure that both employers and their employees receive all available assistance to help through the closure/layoff process.

Michigan Works! Agency (MWA) Operated Programs

- **Work First**
  Work First is designed to establish and maintain a connection to the labor market for Temporary Assistance for Needy Families (TANF) recipients, Non-Custodial Parents (NCPs), and recipients of non-cash assistance such as Child Day Care, Medicaid, and Food Stamps. The funds for Work First Programs are used to provide job search services, education and training programs, and employment-related supportive services such as transportation allowances, uniforms, tools, and automobile repairs

- **Jobs, Education and Training (JET)**
  The JET Program is a partnership between the MWAs, DHS, and DLEG's Bureau of Workforce Programs (BWP) and Michigan Rehabilitation Services (MRS) to connect Michigan's families with the kind of jobs, education, and training opportunities that will help them achieve self-sufficiency and meet the workforce and skill needs of Michigan's

businesses. The JET Program was originally piloted on April 1, 2006, in Kent, Oakland (Madison Heights District), Sanilac, and Wayne (Glendale/Trumbull District) Counties. The initial sites are expected to continue operation through September 30, 2007. In addition, to meet legislative requirements, Oakland and Wayne counties were expanded and other locations added to the pilot.

- **Dislocated Worker Program**
  The Dislocated Worker Program provides workforce investment activities that increase the employment, retention, earnings, and occupational skill level of participants. Services include, but are not limited to, outreach, intake, orientation to other services, initial assessment, job search, placement assistance and group counseling. Training services include on-the- job training, skill-upgrading, and occupational skills training.

- **Trade Adjustment Assistance Program**
  The Trade Adjustment Assistance (TAA) program is a federal entitlement program established under the Trade Act of 1974, as amended. The TAA program provides aid to workers who lose their jobs or whose hours of work and wages are reduced as a result of increased imports. Workers may be eligible for training, job search and relocation allowances, income support, and other re-employment services.

- **Workforce Investment Act (WIA) Youth Program**
  The youth program is linked closely to the local labor market needs and community youth programs and services. The types of services that are included in the youth program include tutoring, study skills training, alternative secondary school offerings, summer employment opportunities, paid and unpaid work experience, occupational skill training, leadership development opportunities, supportive services, adult mentoring, follow-up services, and comprehensive guidance and counseling.

- **Workforce Investment Act (WIA) Adult Program**
  The Workforce Investment Act Adult Program provides workforce investment activities that increase the employment, retention, and earnings of participants, and increase occupational skill attainment by participants. Services include outreach, intake, orientation to other services, initial assessment, job search, placement assistance and group counseling. Training services include on-the- job training, skill-upgrading, and occupational skills training.

- **Displaced Homemaker Program**
  The Displaced Homemaker Program provides employment and training services to displaced homemakers so they can achieve and retain full-time, unsubsidized employment. Displaced homemakers' employment and training needs are assessed on an individual basis and services are tailored to meet each participant's individual needs.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

YOU ARE INVITED TO ATTEND

THE

MICHIGAN'S LONG-TERM CARE CONNECTION ("SINGLE POINT OF ENTRY") INFORMATIONAL FORUM

January 22, 2007
Capital View Building
Conference Rooms A, B, C

210 Townsend Street, Lansing, Michigan
(Driving directions on back)

10:00 am – Noon

An informational session for stakeholders and persons interested in learning about the newly forming Michigan Long-Term Care Connection (Single Point of Entry) for long-term care services in Michigan. Presentations will be followed by a question and answer period.

Sponsored by the Office of Long-Term Care Supports & Services
Michigan Department of Community Health

For More Information: 517.373.3860 or thelen@michigan.gov **RSVP not required.**

The Michigan Long-Term Care Connection (Single Point of Entry) will be a highly-visible and trusted source of information and assistance about long-term care, aiding Michigan residents with planning and access to needed services & supports, in accordance with their preferences.

DRIVING DIRECTIONS

January 22, 2007 Capital View Building, Conf Rooms A, B, C

210 Townsend Street, Lansing, Michigan

The Capitol View Building is located on the southeast corner of West Allegan Street and Townsend Street. Parking is available, for a fee, in two city-run parking ramps. One ramp is located on Townsend Street, adjacent to the Capitol View Building. The other ramp is at the corner of West Allegan Street and South Capitol Avenue. Parking is also available at meters throughout the downtown area.

From Grand Rapids: Take I-96E to I-496E. Follow I-496E to the Pine Street Exit (Exit 6). Follow the off ramp to West Main Street and continue down West Main Street. Turn left on to Walnut Street (see map below).

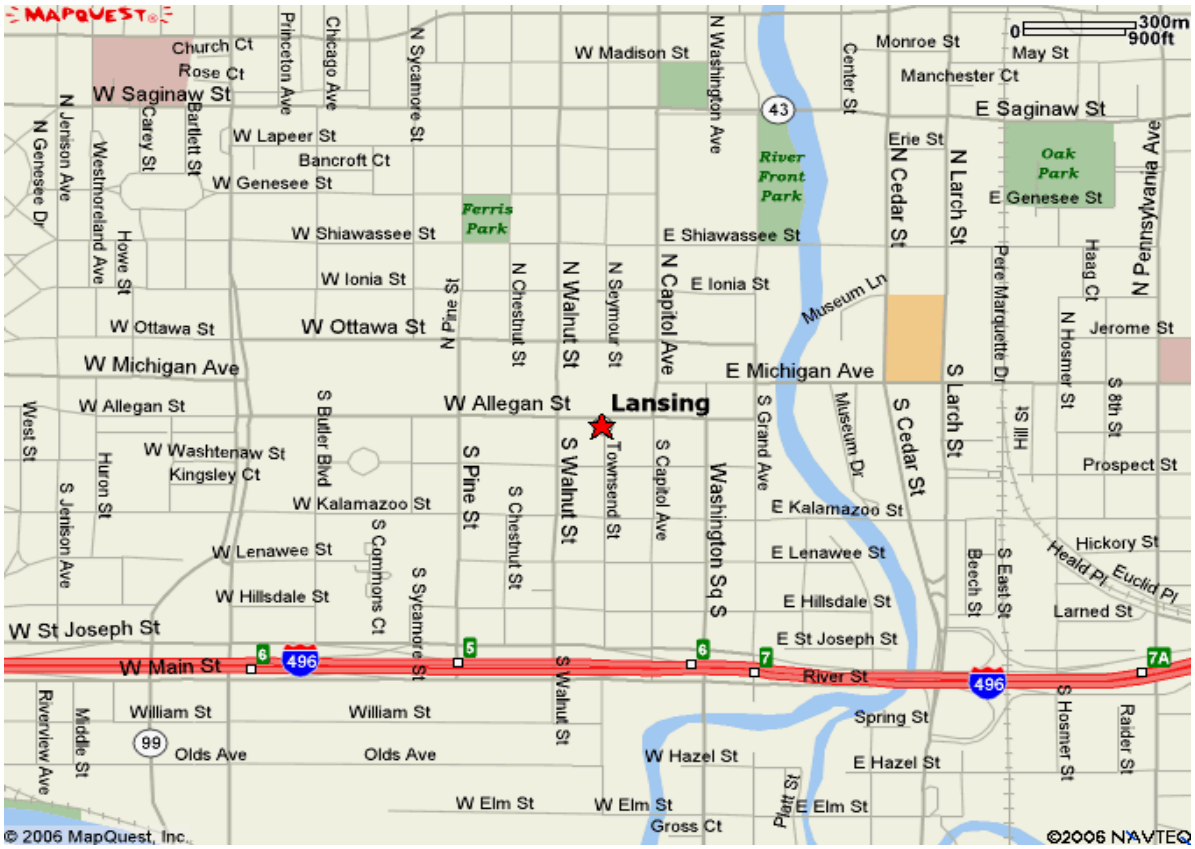
From Clare and Points North: Follow US-127S to I-496W. Take I-496W to the Walnut Street Exit (Exit 6). Follow the off ramp to West St. Joseph Street and continue on St. Joseph Street for one block. Turn right on to Walnut Street (see map below)

From Flint: Take I-69W to US-127S. Follow US-127S to I-496W. Take I-496W to the Walnut Street Exit (Exit 6). Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

From Detroit: Take I-96W to Lansing which runs right into I-496W. Get on I-496W and continue to Exit 6 which is Walnut Street. Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

From Jackson and Points South: Take US-127N from Jackson to Lansing. At I-96, I-496 will join US-127N. Follow I-496W to the Walnut Street Exit (Exit 5). Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

From Southwest Michigan (Kalamazoo-Benton Harbor-St. Joseph Area): Travel North on I-69 to Lansing. Follow I-69 to I-496E. Follow I-496E to the Pine Street Exit (Exit 6). Follow the off ramp to W. Main Street and continue down W. Main Street. Turn left on to Walnut Street (see map below)



Act No. 634
Public Acts of 2006
Approved by the Governor
December 30, 2006
Filed with the Secretary of State
January 4, 2007
EFFECTIVE DATE: January 4, 2007

STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Reps. Shaffer, Amos, Vander Veen, Caul, Proos, LaJoy, Marleau, Nitz, Pearce, Zelenko, Byrnes, Alma Smith, Farrah, Pastor, Casperson, Kahn, Kooiman, Palsrok, Newell, Ball, Green, Stahl, Robertson, Wojno, Gillard, Clack, Bennett, Mortimer, Hansen, Sheen, Farhat, Sak, Emmons, Vagnozzi, Donigan, Hune, Garfield, Polidori, Spade, Byrum, Gosselin, Gleason, Waters, McConico, Anderson, Stewart, Kolb, Lipsey, Meyer, Hummel, Williams, Adamini, Brown, Virgil Smith, Hopgood, Kathleen Law, Bieda, Meisner, Acciavatti, Condino, Stakoe, Caswell, Nofs, Wenke, Ward, Steil, Huizenga, Moolenaar, Angerer, Baxter, Booher, Cheeks, Clemente, Espinoza, Gonzales, Hildenbrand, Rick Jones, Leland, Lemmons, III, Lemmons, Jr., McDowell, Miller, Moore, Rocca, Hood and Murphy

ENROLLED HOUSE BILL No. 5389

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," (MCL 400.1 to 400.119b) by adding sections 109i and 109j.

The People of the State of Michigan enact:

Sec. 109i. (1) The director of the department of community health shall designate and maintain locally or regionally based single point of entry agencies for long-term care that shall serve as visible and effective access points for individuals seeking long-term care and that shall promote consumer choice and quality in long-term care options.

(2) The department of community health shall monitor single point of entry agencies for long-term care to assure, at a minimum, all of the following:

(a) That bias in functional and financial eligibility determination or assistance and the promotion of specific services to the detriment of consumer choice and control does not occur.

(b) That consumer assessments and support plans are completed in a timely, consistent, and quality manner through a person-centered planning process and adhere to other criteria established by this section and the department of community health.

(c) The provision of quality assistance and supports.

(d) That quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.

(e) Consumer access to an independent consumer advocate.

(f) That data and outcome measures are being collected and reported as required under this act and by contract.

(g) That consumers are able to choose their supports coordinator.

(3) The department of community health shall establish and publicize a toll-free telephone number for areas of the state in which a single point of entry agency is operational as a means of access.

(4) The department of community health shall require that single point of entry agencies for long-term care perform the following duties and responsibilities:

(a) Provide consumers and any others with unbiased information promoting consumer choice for all long-term care options, services, and supports.

(b) Facilitate movement between supports, services, and settings in a timely manner that assures consumers' informed choice, health, and welfare.

(c) Assess consumers' eligibility for all medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.

(d) Assist consumers in obtaining a financial determination of eligibility for publicly funded long-term care programs.

(e) Assist consumers in developing their long-term care support plans through a person-centered planning process.

(f) Authorize access to medicaid programs for which the consumer is eligible and that are identified in the consumer's long-term care supports plan. The single point of entry agency for long-term care shall not refuse to authorize access to medicaid programs for which the consumer is eligible.

(g) Upon request of a consumer, his or her guardian, or his or her authorized representative, facilitate needed transition services for consumers living in long-term care settings if those consumers are eligible for those services according to a policy bulletin approved by the department of community health.

(h) Work with designated representatives of acute and primary care settings, facility settings, and community settings to assure that consumers in those settings are presented with information regarding the full array of long-term care options.

(i) Reevaluate the consumer's eligibility and need for long-term care services upon request of the consumer, his or her guardian, or his or her authorized representative or according to the consumer's long-term care support plan.

(j) Except as otherwise provided in subdivisions (k) and (*l*), provide the following services within the prescribed time frames:

(*i*) Perform an initial evaluation for long-term care within 2 business days after contact by the consumer, his or her guardian, or his or her authorized representative.

(*ii*) Develop a preliminary long-term care support plan in partnership with the consumer and, if applicable, his or her guardian or authorized representative within 2 business days after the consumer is found to be eligible for services.

(*iii*) Complete a final evaluation and assessment within 10 business days from initial contact with the consumer, his or her guardian, or his or her authorized representative.

(k) For a consumer who is in an urgent or emergent situation, within 24 hours after contact is made by the consumer, his or her guardian, or his or her authorized representative, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian or authorized representative.

(*l*) Except as provided in subsection (20), for a consumer who receives notice that within 72 hours he or she will be discharged from a hospital, within 24 hours after contact is made by the consumer, his or her guardian, his or her authorized representative, or the hospital discharge planner, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian, his or her authorized representative, or the hospital discharge planner.

(m) Initiate contact with and be a resource to hospitals within the area serviced by the single point of entry agencies for long-term care.

(n) Provide consumers with information on how to contact an independent consumer advocate and a description of the advocate's mission. This information shall be provided in a publication prepared by the department of community health in consultation with these entities. This information shall also be posted in the office of a single point of entry agency.

(o) Collect and report data and outcome measures as required by the department of community health, including, but not limited to, the following data:

(*i*) The number of referrals by level of care setting.

(*ii*) The number of cases in which the care setting chosen by the consumer resulted in costs exceeding the costs that would have been incurred had the consumer chosen to receive care in a nursing home.

(*iii*) The number of cases in which admission to a long-term care facility was denied and the reasons for denial.

(*iv*) The number of cases in which a memorandum of understanding was required.

(*v*) The rates and causes of hospitalization.

(*vi*) The rates of nursing home admissions.

(*vii*) The number of consumers transitioned out of nursing homes.

(*viii*) The average time frame for case management review.

(*ix*) The total number of contacts and consumers served.

(*x*) The data necessary for the completion of the cost-benefit analysis required under subsection (11).

(*xi*) The number and types of referrals made.

(*xii*) The number and types of referrals that were not able to be made and the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

(p) Maintain consumer contact information and long-term care support plans in a confidential and secure manner.

(q) Provide consumers with a copy of their preliminary and final long-term care support plans and any updates to the long-term care plans.

(5) The department of community health, in consultation with the office of long-term care supports and services, the Michigan long-term care supports and services advisory commission, the department, and the office of services to the aging, shall promulgate rules to establish criteria for designating local or regional single point of entry agencies for long-term care that meet all of the following criteria:

(a) The designated single point of entry agency for long-term care does not provide direct or contracted medicaid services. For the purposes of this section, the services required to be provided under subsection (4) are not considered medicaid services.

(b) The designated single point of entry agency for long-term care is free from all legal and financial conflicts of interest with providers of medicaid services.

(c) The designated single point of entry agency for long-term care is capable of serving as the focal point for all individuals, regardless of age, seeking information about long-term care in their region, including individuals who will pay privately for services.

(d) The designated single point of entry agency for long-term care is capable of performing required consumer data collection, management, and reporting.

(e) The designated single point of entry agency for long-term care has quality standards, improvement methods, and procedures in place that measure consumer satisfaction and monitor consumer outcomes.

(f) The designated single point of entry agency for long-term care has knowledge of the federal and state statutes and regulations governing long-term care settings.

(g) The designated single point of entry agency for long-term care maintains an internal and external appeal process that provides for a review of individual decisions.

(h) The designated single point of entry agency for long-term care is capable of delivering single point of entry services in a timely manner according to standards established by the department of community health and as prescribed in subsection (4).

(6) A single point of entry agency for long-term care that fails to meet the criteria described in this section or other fiscal and performance standards prescribed by contract and subsection (7) or that intentionally and knowingly presents biased information that is intended to steer consumer choice to particular long-term care supports and services is subject to disciplinary action by the department of community health. Disciplinary action may include, but is not limited to, increased monitoring by the department of community health, additional reporting, termination as a designated single point of entry agency by the department of community health, or any other action as provided in the contract for a single point of entry agency.

(7) Fiscal and performance standards for a single point of entry agency include, but are not limited to, all of the following:

(a) Maintaining administrative costs that are reasonable, as determined by the department of community health, in relation to spending per client.

(b) Identifying savings in the annual state medicaid budget or limits in the rate of growth of the annual state medicaid budget attributable to providing services under subsection (4) to consumers in need of long-term care services and supports, taking into consideration medicaid caseload and appropriations.

(c) Consumer satisfaction with services provided under subsection (4).

(d) Timeliness of delivery of services provided under subsection (4).

(e) Quality, accessibility, and availability of services provided under subsection (4).

(f) Completing and submitting required reporting and paperwork.

(g) Number of consumers served.

(h) Number and type of long-term care services and supports referrals made.

(i) Number and type of long-term care services and supports referrals not completed, taking into consideration the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

(8) The department of community health shall develop standard cost reporting methods as a basis for conducting cost analyses and comparisons across all publicly funded long-term care systems and shall require single point of entry agencies to utilize these and other compatible data collection and reporting mechanisms.

(9) The department of community health shall solicit proposals from entities seeking designation as a single point of entry agency and, except as provided in subsection (16) and section 109j, shall initially designate not more than 4 agencies to serve as a single point of entry agency in at least 4 separate areas of the state. There shall not be more than 1 single point of entry agency in each designated area. An agency designated by the department of community health under this subsection shall serve as a single point of entry agency for an initial period of up to 3 years, subject to the provisions of subsection (6). In accordance with subsection (17), the department shall require that a consumer residing in an area served by a single point of entry agency designated under this subsection utilize that agency if the consumer is seeking eligibility for medicaid long-term care programs.

(10) The department of community health shall evaluate the performance of single point of entry agencies under this section on an annual basis.

(11) The department of community health shall engage a qualified objective independent agency to conduct a cost-benefit analysis of single point of entry, including, but not limited to, the impact on medicaid long-term care costs. The cost-benefit analysis required in this subsection shall include an analysis of the cost to hospitals when there is a delay in a patient's discharge from a hospital due to the hospital's compliance with the provisions of this section.

(12) The department of community health shall make a summary of the annual evaluation, any report or recommendation for improvement regarding the single point of entry, and the cost-benefit analysis available to the legislature and the public.

(13) Not earlier than 12 months after but not later than 24 months after the implementation of the single point of entry agency designated under subsection (9), the department of community health shall submit a written report to the senate and house of representatives standing committees dealing with long-term care issues, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on community health, and the senate and house fiscal agencies regarding the array of services provided by the designated single point of entry agencies and the cost, efficiencies, and effectiveness of single point of entry. In the report required under this subsection, the department of community health shall provide recommendations regarding the continuation, changes, or cancellation of single point of entry agencies based on data provided under subsections (4) and (10) to (12).

(14) Beginning in the year the report is submitted and annually after that, the department of community health shall make a presentation on the status of single point of entry and on the summary information and recommendations required under subsection (12) to the senate and house of representatives appropriations subcommittees on community health to ensure that legislative review of single point of entry shall be part of the annual state budget development process.

(15) The department of community health shall promulgate rules to implement this section not later than 270 days after submitting the report required in subsection (13).

(16) The department of community health shall not designate more than the initial 4 agencies designated under subsection (9) to serve as single point of entry agencies or agencies similar to single point of entry agencies unless all of the following occur:

(a) The written report is submitted as provided under subsection (13).

(b) Twelve months have passed since the submission of the written report required under subsection (13).

(c) The legislature appropriates funds to support the designation of additional single point of entry agencies.

(17) A single point of entry agency for long-term care shall serve as the sole agency within the designated single point of entry area to assess a consumer's eligibility for medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.

(18) Although a community mental health services program may serve as a single point of entry agency to provide services to individuals with mental illness or developmental disability, community mental health services programs are not subject to the provisions of this act.

(19) Medicaid reimbursement for health facilities or agencies shall not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the 4 pilot single point of entry agencies designated under subsection (9).

(20) The provisions of this section and section 109j do not apply after December 31, 2011.

(21) Funding for the MI Choice Waiver program shall not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the 4 pilot single point of entry agencies designated under subsection (9).

(22) A single point of entry agency for long-term care may establish a memorandum of understanding with any hospital within its designated area that allows the single point of entry agency for long-term care to recognize and utilize an initial evaluation and preliminary long-term care support plan developed by the hospital discharge planner if those plans were developed with the consumer, his or her guardian, or his or her authorized representative.

(23) For the purposes of this section:

(a) "Administrative costs" means the costs that are used to pay for employee salaries not directly related to care planning and supports coordination and administrative expenses necessary to operate each single point of entry agency.

(b) "Administrative expenses" means the costs associated with the following general administrative functions:

(*i*) Financial management, including, but not limited to, accounting, budgeting, and audit preparation and response.

(*ii*) Personnel management and payroll administration.

(*iii*) Purchase of goods and services required for administrative activities of the single point of entry agency, including, but not limited to, the following goods and services:

(A) Utilities.

(B) Office supplies and equipment.

(C) Information technology.

(D) Data reporting systems.

(E) Postage.

(F) Mortgage, rent, lease, and maintenance of building and office space.

(G) Travel costs not directly related to consumer services.

(H) Routine legal costs related to the operation of the single point of entry agency.

(c) "Authorized representative" means a person empowered by the consumer by written authorization to act on the consumer's behalf to work with the single point of entry, in accordance with this act.

(d) "Guardian" means an individual who is appointed under section 5306 of the estates and protected individuals code, 1998 PA 386, MCL 700.5306. Guardian includes an individual who is appointed as the guardian of a minor under section 5202 or 5204 of the estates and protected individuals code, 1998 PA 386, MCL 700.5202 and 700.5204, or who is appointed as a guardian under the mental health code, 1974 PA 258, MCL 300.1001 to 300.2106.

(e) "Informed choice" means that the consumer is presented with complete and unbiased information on his or her long-term care options, including, but not limited to, the benefits, shortcomings, and potential consequences of those options, upon which he or she can base his or her decision.

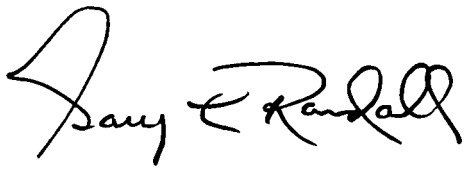
(f) "Person-centered planning" means a process for planning and supporting the consumer receiving services that builds on the individual's capacity to engage in activities that promote community life and that honors the consumer's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the consumer desires or requires.

(g) "Single point of entry" means a program from which a current or potential long-term care consumer can obtain long-term care information, screening, assessment of need, care planning, supports coordination, and referral to appropriate long-term care supports and services.

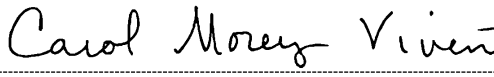
(h) "Single point of entry agency" means the organization designated by the department of community health to provide case management functions for consumers in need of long-term care services within a designated single point of entry area.

Sec. 109j. The department of community health shall not designate more than the initial 4 agencies designated under section 109i(9) to serve as single point of entry agencies or agencies similar to single point of entry agencies unless the conditions of section 109i(16) are met and the legislature repeals this section.

This act is ordered to take immediate effect.



Clerk of the House of Representatives



Secretary of the Senate

Approved _____

_____

Governor

Act No. 674
Public Acts of 2006
Approved by the Governor
January 8, 2007
Filed with the Secretary of State
January 10, 2007
EFFECTIVE DATE: January 10, 2007

STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Reps. Vander Veen, Zelenko, Newell, Marleau, Brandenburg, Gaffney, Hummel, Caswell, Stahl, Amos, Green, Hansen, Booher, Sheen, Kahn and Huizenga

ENROLLED HOUSE BILL No. 6478

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," by amending sections 112b, 112c, and 112e (MCL 400.112b, 400.112c, and 400.112e), as added by 1995 PA 85; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

Sec. 112b. As used in this section and sections 112c to 112e:

(a) "Asset disregard" means, with regard to the state's medical assistance program, disregarding any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

(b) "Long-term care insurance policy" means a policy described in chapter 39 of the insurance code of 1956, 1956 PA 218, MCL 500.3901 to 500.3955.

(c) "Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in section 1917(b) of the social security act, 42 USC 1396p.

(d) "Long-term care partnership program policy" means a qualified long-term care insurance policy that the commissioner of the office of financial and insurance services certifies as meeting the requirements of section 1917(b) of the social security act, 42 USC 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(e) "Medicaid" means the program of medical assistance established by the department of community health under section 105.

Sec. 112c. (1) Subject to subsection (5), the department of community health in conjunction with the office of financial and insurance services and the department of human services shall establish a long-term care partnership program in Michigan to provide for the financing of long-term care through a combination of private insurance and medicaid. It is the intent of the long-term care partnership program to do all of the following:

(a) Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

(b) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under medicaid without first being required to substantially exhaust their resources.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) An individual who is a beneficiary of a Michigan long-term care partnership program policy is eligible for assistance under the state's medical assistance program using the asset disregard as provided under subsection (5).

(3) The department of community health shall pursue reciprocal agreements with other states to extend the asset disregard to Michigan residents who purchased long-term care partnership policies in other states that are compliant with title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(4) Upon diminishment of assets below the anticipated remaining benefits under a long-term care partnership program policy, certain assets of an individual, as provided under subsection (5), shall not be considered when determining any of the following:

(a) Medicaid eligibility.

(b) The amount of any medicaid payment.

(c) Any subsequent recovery by the state of a payment for medical services or long-term care services.

(5) Not later than 270 days after the effective date of the amendatory act that added this subsection, the department of community health shall apply to the United States department of health and human services for an amendment to the state's medicaid state plan to establish that the assets an individual owns and may retain under medicaid and still qualify for benefits under medicaid at the time the individual applies for benefits is increased dollar-for-dollar for each dollar paid out under the individual's long-term care insurance policy if the individual is a beneficiary of a qualified long-term care partnership program policy.

(6) If the long-term care partnership program is discontinued, an individual who purchased a Michigan long-term care partnership program policy before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171.

(7) The department of community health shall contract with the Michigan medicare medicaid assistance program or department of community health designated single point of entry agencies, or both, to provide counseling services under the Michigan long-term care partnership program.

(8) The department of community health, in consultation with the department of human services and the office of financial and insurance services, shall develop a notice to consumers detailing in plain language the pertinent provisions of qualified state long-term care insurance partnership policies as they relate to medicaid eligibility and shall determine the appropriate distribution of the notice. The notice shall be available in a printable form on the office of financial and insurance services's website.

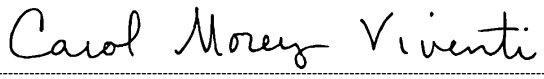
(9) The department, the department of community health, and the office of financial and insurance services shall post, on their respective websites, information on how to access the national clearinghouse established under the federal deficit reduction act of 2005, Public Law 109-171, when the national clearinghouse becomes available to consumers.

Sec. 112e. The department of community health, in consultation with the department of human services and the office of financial services, may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, as necessary to implement the partnership program in accordance with the requirements of section 1917(b) of the social security act, 42 USC 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and applicable federal regulations or guidelines.

Enacting section 1. Section 112d of the social welfare act, 1939 PA 280, MCL 400.112d, is repealed.

This act is ordered to take immediate effect.

Clerk of the House of Representatives



Secretary of the Senate

Approved _____

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Governor